STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495375	A. Building B. Wing	06/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emporia Rehabilitation and Healthcare Center	200 Weaver Avenue Emporia, VA 23847

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40452 Based on staff interviews, clinical record review, and in the course of a complaint investigation, the facility staff failed to mitigate a known accident hazard for one Resident (Resident #1) in a survey sample size of 4 Residents. Specifically, Resident #1 needed assistance and guidance with dressing and had a known behavior of holding her dialysis catheter and picking at the dialysis catheter dressing. On the morning of 05/27/2022, Resident #1 was not assisted with dressing and found half-dressed, lying across the bed, no dressing on the dialysis catheter site, and one of the port caps removed resulting in Resident #1's death by exsanguination (severe loss of blood). This is harm. The findings included: On 06/08/2022, Resident #1's closed clinical record was reviewed. Resident #1's most recent Minimum Data Set with an Assessment Reference Date of 05/03/2022 was coded as a Significant Change in Status assessment. Cognitive Skills for Daily Decision-Making were coded as severely impaired. Functional status for dressing was coded as requiring limited assistance from staff meaning the resident was highly involved in activity and the staff provided guided maneuvering of limbs or other non-weight-bearing assistance with a one person physical assist. A review of the progress notes for April and May 2022 revealed that Resident #1 was admitted to the hospital on 04/21/2022 due to multiple abscesses on the left arm and returned to the facility on [DATE] with a double lumen catheter in the right internal jugular (IJ) for dialysis access. A physician's order dated 05/03/2022 documented Check access right double lumen IJ [internal jugular vessel] for bleeding, redness, tenderness, and swelling. The Treatment Administration Record associated with this order was signed off as administered on the night shift 05/26/2022 and on the day shift 05/27/2022. Resident #1's care plan was reviewed. The care plan did not document any behaviors pertaining to touching the dialysis catheter or disrupting the dressing. A progress note dated 05/27/2022 at 7:10 A.M. documented, Resident noted in bed asleep at present time. No distress noted. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A progress note dated 05/27/2022 at 10:10 A.M. documented, CNA yelled for this writer to come to room [number]. Resident noted on bed on back with legs hanging off bed. Resident has pants on but no shirt noted on resident. Large pool of bright red blood noted on bed surrounding resident. Bright red blood noted on floor. Dialysis double lumen catheter noted in right chest wall. No active bleeding noted from dialysis catheter. Blue cap from dialysis catheter noted beside resident. Checked carotid and radial pulse. Resident is a DNR. No pulse noted. No signs of life. Resident is pale and warm to touch. Ask floor tech supervisor to call nurses to [name of unit]. Central nurse RN arrive to access resident. All other facility nurses arrived to room to assist. DON informed of incident. NP informed of incident. Family called by Central nurse. They stated to call [name] funeral home. 911 called per protocol. EMT arrived stated that they spoke with [physician name] and he pronounced resident death at 0853. Funeral home called and body was release [sic] to them upon their arrival. On 06/08/2022 at approximately 3:15 P.M., CNA B working on the Memory Care unit was interviewed. CNA B verified they worked with Resident #1 the day before the incident on 05/27/2022. When asked about Resident #1's functional status for dressing, CNA B stated that Resident #1 needed assistance getting dressed but would, at times, get herself dressed. When asked if Resident #1 had any behaviors associated with the dialysis catheter, CNA B stated that Resident #1 would mess with it. CNA B stated if Resident #1 took notice of the catheter, she would hold it. CNA B stated that the day before the incident on 05/27/2022, CNA B observed Resident #1 holding the dialysis catheter. CNA B stated that they (1) told Resident #1 not to touch it and that Resident #1 was easily redirected. When asked if this was reported to the nurse, CNA B stated they did report it to the nurse but they could not remember the nurse's name because it was an agency nurse. When asked about the dressing for the dialysis catheter, CNA B stated that the site would usually have a dressing but the tubing was not wrapped. On 06/08/2022 at 3:45 P.M., LPN D was interviewed. LPN D verified she was an agency nurse working at the facility for the past three months. LPN D verified she was the nurse working with Resident #1 on the day of the incident. LPN D stated that Resident #1 could dress herself. When asked about the dialysis catheter dressing prior to the incident, LPN D stated usually the site was dressed but the tubing was not wrapped. LPN D stated that usually the tubing, the clamps, and the caps could be seen. LPN D stated Resident #1 had a double lumen dialysis catheter; one lumen with a red cap; one lumen with a blue cap. When asked about Resident #1's behaviors pertaining to the dialysis catheter, LPN D stated she personally did not ever see Resident #1 messing with her dialysis catheter. On 06/08/2022 at 4:25 P.M., CNA E was interviewed. CNA E verified she discovered Resident #1 on the morning of the incident on 05/27/2022. CNA E verified she was assigned to care for Resident #1 that day. CNA E stated that she got into work an hour late that day. CNA E stated she did call to let someone know she would be late but could not recall the name of the person she notified. CNA E stated that when she arrived on the unit, other staff members were passing breakfast trays so she also started passing trays. CNA E stated that 7:56 A.M., she entered Resident #1's room with the breakfast tray and found Resident #1 lying across her bed with blood all around. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 06/08/2022 at 4:35 P.M., the Director of Nursing (DON) was interviewed in the conference room with Surveyor B and Surveyor C present. When asked if the incident involving Resident #1 on 05/27/2022 was investigated, the DON stated it was investigated. When asked about the findings of the investigation and any changes made as a result of the investigation, the DON stated that all Residents with dialysis catheters were checked to ensure the dialysis catheter site was secured with gauze and tape. The DON stated that the orders were revamped to include calling the dialysis center if the dialysis catheter didn't have a dressing on. Also, the facility staff placed hemostats [a clamp] and dressing supplies at the bedside of all Residents with a dialysis catheter in case something was to happen and they needed something right then. When asked if staff received any education related to the incident, the DON stated that nurses and some aides received education to report it if the dialysis dressing is off. When asked for the in-service sheets, the DON stated that she remembers educating everyone but did not recall having them sign in-service sheets. When asked if Resident #1 had a dressing on her dialysis catheter the morning of the incident, the DON stated that Resident #1 did not have a dressing on that morning. The DON stated she checked the eMAR (electronic Medication Administration Record) and it was checked off as on there. The DON indicated that at some point, the dressing came off. When asked if Resident #1 had behaviors of touching her dialysis catheter or disrupting the dressing, the DON stated that Resident #1 would mess with it at times and the staff would remind her not to mess with it. The DON stated that Resident #1 would pick at the tape and the dressing. On 06/08/2022 at approximately 5:30 P.M., the administrator and DON were notified of findings. At approximately 6:15 P.M., the DON provided a copy of a written statement, signed by the DON, dated 06/08/2022 which documented the following excerpt: I was not made aware of resident's behavior of picking at her dialysis catheter site until the date of this incident. On 06/08/2022, the facility staff provided a copy of their policy entitled, Hemodialysis Access Care. Under the header, Care immediately following dialysis treatment in Section (1) and (2) documented, The dressing change is done in the dialysis center post-treatment. If dressing becomes wet, dirty, or not intact, the dressing shall be changed by a licensed nurse trained in this procedure. (Note: Check with State Nurse Practice Act to determine licensure and competency requirements). (1) Singular they (a generic third-person singular pronoun) is being used to protect anonymity. See https://apastyle.apa.org/style-grammar-guidelines/grammar/singular-they